MDR Tracking Number: M5-04-0356-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 2, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the joint mobilizations, therapeutic procedures, neuromuscular reeducations, Kinetic activities, physical therapy, ultrasound therapy, myofasical release, electrical stimulation, manipulation/cervical, training activities- daily living was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment of joint mobilizations, therapeutic procedures, neuromuscular reeducations, Kinetic activities, physical therapy, ultrasound therapy, myofasical release, electrical stimulation, manipulation/cervical, training activities- daily living was not found to be medically necessary, reimbursement for dates of service 07-02-02 through 10-28-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 10th day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
GR/gr

December 8, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-04-0356-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 48 year-old female who sustained a work related injury on ___. The patient reported that while at work she was dragging a forklift and a tub of raw material when she experienced a popping sensation in her back while bending and pushing. The patient was evaluated in the emergency room immediately after the injury and again the following day by her family practitioner. The patient underwent a discogram, myelogram, and EMG/NCV testing. The diagnoses for this patient has included lumbar disc herniation, lumbar strain, nerve root displacement, low back pain, radiculopathy, myospasms, altered gait and hyperesthesia. Treatment for this patient's condition has included physical therapy, chiropractic care, physical therapy and 4 epidural steroid injections. The patient also underwent a hemilaminectomy and discectomy on 11/4/02. The patient has also been evaluated by pain management and an orthopedic specialist.

Requested Services

Joint mobilization, therapeutic procedure, neuromuscular reeducation, kinetic activities, physical therapy, ultrasound therapy, myofascial release, electrical stimulation, manipulation/cervical, training activities-daily living from 7/2/02 through 10/28/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 48 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient has included lumbar disc herniation, lubar strain, nerve root displacement, low back pain, radiculopathy, myosapasms, altered gait and hyperesthesia.

The ___ chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy, chiropractic care, epidural steroid injections and a hemilaminectomy and discectomy on 11/4/02. The ___ chiropractor reviewer indicated that the treating physician listed the treatment rendered from 7/16/02 through 8/27/02 as post-injection rehabilitation. However, the ___ chiropractor reviewer explained that the patient underwent a discogram on 6/28/02. The ___ chiropractor reviewer further explained that a discogram is a diagnostic procedure and does not require post-injection rehabilitation. The ___ chiropractor reviewer noted that the treatments provided from 8/29/02 through 10/28/02 were listed as prehabilitation. The ___ chiropractor reviewer explained that as early 12/11/01 the patient had been receiving therapeutic exercises, joint mobilization, and myofascial release. The ___ chiropractor reviewer explained that these treatments are the exact treatments provided to the patient between 8/28/02 and 10/28/02. The ___ chiropractor reviewer indicated that prehabilitation is ideal to patients who are deconditioned (Introduction to Rehabilitation). The ___ chiropractor reviewer noted that this patient had over 8 months of prior active therapy and was not deconditioned. Therefore, the ___ chiropractor consultant concluded that the joint mobilization, therapeutic procedure, neuromuscular reeducation, kinetic activities, physical therapy, ultrasound therapy, myofascial release, electrical stimulation, manipulation/cervical, training activities-daily living from 7/2/02 through 10/28/02 were not medically necessary to treat this patient's condition.

Sincerely,